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UC Health Center for Reproductive Health

Female Patient History Form

1. IDENTIFYING INFORMATION

Name _____ DOB _____/_____/_____ Age _____

Significant Other Name _____ DOB _____/_____/_____ Age _____

Primary Language spoken: □ English □ Spanish □ Other:_____

Date this form completed _____/_____/_____ Referred by: _____

Primary Ob/Gyn _____Address _____

Primary Care MD _____Address _____

How long have you been attempting conception? _____Number of years married/together _____

Reasons you are coming to see us: _____

_____

What questions do you want answered at this visit? _____

_____

2. PREGNANCY HISTORY

Total number of ALL pregnancies _____ Full term births _____ Premature births (less than 37 weeks) _____

Miscarriages (less than 20 weeks) _____ Elective abortions _____ Ectopic/Tubal Pregnancies _____ Adopted children _____

	Date	Miscarriage?	Elective Abortion?	Ectopic?	Months to conceive?	Infertility Treatment?	Weight and sex?	C-section?	Complications?	Is current partner the father?
1.										
2.										
3.										
4.										
5.										

3. CONTRACEPTIVE USE

	Type	From when to when	Reason discontinued
1.			
2.			

4. SURGERIES AND HOSPITALIZATIONS

	Date	Reason and type of surgery	Where	Physician
1.	:		:	:
2.	:		:	:
3.	:		:	:
4.	:		:	:

5. MEDICAL HISTORY

Do you have or have you had?

- ❑ Cancer
- ❑ Diabetes
- ❑ Hypertension
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Rheumatic fever
- ❑ Scarlet fever
- ❑ Mitral valve prolapse
- ❑ Heart murmur
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Hepatitis / liver disorder
- ❑ Gall bladder problems
- ❑ Ulcers
- ❑ Colitis / enteritis
- ❑ Kidney disorder
- ❑ Rubella
- ❑ Anesthetic complication
- ❑ Mumps
- ❑ Chicken pox
- ❑ Mononucleosis
- ❑ Serious injury / accident
- ❑ Blood transfusion
- ❑ Psychiatric disorder
- ❑ Seizures
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ Bleeding disorder
- ❑ Thyroid disorder
- ❑ Recent immunization

Any medical problem not listed above (please list type, dates, treatments)

1. _____
2. _____
3. _____
4. _____

List all prescriptions and over-the-counter drugs used during the past year

	Date	Dose and frequency	From when to when	Reason
1.	_____ :	_____ :	_____ :	_____
2.	_____ :	_____ :	_____ :	_____
3.	_____ :	_____ :	_____ :	_____
4.	_____ :	_____ :	_____ :	_____

6. ALLERGIES

	Drug or substance	Reaction
1.	_____ :	_____
2.	_____ :	_____

7. MENSTRUAL/HORMONAL

Menstrual cycle pattern (check all that apply): ❑ Regular periods ❑ Irregular periods ❑ Spotting before periods ❑ No periods
❑ Heavy periods ❑ Light periods ❑ Bleeding between periods

Age at first period ..... First day of last two menstrual periods _____/_____/_____ and _____/_____/_____

How many days from start of one period to start of the next period? ..... How many days of bleeding do you have? .....days

Pelvic pain/cramps: ❑ none ❑ during period ❑ before period ❑ after period ❑ at mid cycle
❑ during intercourse ❑ with bowel movements ❑ with urination ❑ cause you to miss work ❑ cause you to miss usual activities

Pelvic pain/cramps are: ❑ mild ❑ moderate ❑ severe
❑ worsening ❑ improving ❑ no change ❑ in midline ❑ on right side ❑ on left side

Do you have or have you had? (Check all that apply)

❑ Hot flashes ❑ Increased facial or body hair ❑ Breast discharge ❑ Increased acne

Please explain a "Yes" answer: _____

8. GYNECOLOGIC / INFECTION

Last pap smear _____/_____/_____ Last mammogram _____/_____/_____

Do you have or have you had?

- ❑ Pelvic infection
- ❑ Chlamydia
- ❑ Endometriosis
- ❑ Pelvic adhesions
- ❑ Cervicitis
- ❑ Genital herpes
- ❑ Appendicitis
- ❑ Colitis or enteritis
- ❑ Uterine fibroids or myomas
- ❑ Abnormal shape of uterus
- ❑ Recurrent vaginitis
- ❑ Abnormal Pap smears
- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Mycoplasma
- ❑ Ureaplasma
- ❑ Genital warts / condyloma
- ❑ Cryo (freezing) or surgery of the cervix
- ❑ Ovarian cysts
- ❑ Hepatitis
- ❑ Cytomegalovirus (CMV)
- ❑ HIV/AIDS
- ❑ Trichomonas
- ❑ Other _____

9. SEXUAL HISTORY

Are you sexually active? ❑ Yes ❑ No

How many times do you have intercourse per week? _____

Do you have pain with intercourse? ❑ Yes ❑ No

Is your partner ❑ Male ❑ Female

Have you used over the counter ovulation kits to time intercourse? ❑ Yes ❑ No

Do you use lubricants during intercourse? ❑ Yes – what types? _____ ❑ No

10. OTHER HISTORY

Your occupation:.....

Alcohol - type and number per week:…….....

Cigarettes – How many per day? .....

How many years? ..... Quit – When? .....

Marijuana - amount: .....

Other drugs - type and amount: ....

Caffeinated beverages (coffee, tea, soda) per day: .....

Ever used intravenous drugs? ❑ yes ❑ no

Radiation exposure: ❑ yes ❑ no

11. SYSTEMIC REVIEW

Height _____ Weight _____ Maximum Weight _____ Minimum Weight _____ Weight change in last 2 yrs _____

Do/have you participated in any significant dietary changes over the past 3 years?.....

Do/have you participated in any exercise programs over the past 3 years?.....

If so please document exercise: type ..... hrs/week .....

- The effect of being overweight on fertility therapies have been well documented.
- Please speak with your physician regarding weight loss attempts and ideal weight range for you height.
- Obesity does not usually cause infertility but it may have significant impact on treatment responses & may have multiple negative effects on both you & the fetus

Check all that applies:

General
- ❑ Recent weight gain / loss
- ❑ Anorexia/bulimia
- ❑ Lack of energy
- ❑ Fever/Chills
- ❑ Other _____

Endocrine/Hormonal
- ❑ Diabetes
- ❑ Hair loss
- ❑ Thyroid gland problems
- ❑ Excessive thirst or hunger
- ❑ Temperature intolerance – Hot flashes or feeling cold
- ❑ Other _____

Gastrointestinal
- ❑ Nausea/vomiting
- ❑ Ulcers
- ❑ Diarrhea
- ❑ Constipation
- ❑ Irritable Bowel Syndrome
- ❑ Change in bowel habits
- ❑ Other _____

Musculoskeletal
- ❑ Muscle weakness
- ❑ Decreased energy/stamina
- ❑ Rheumatoid arthritis
- ❑ Lupus erythematosus
- ❑ Other _____

Mental Health Problems
- ❑ Depression ❑ Anxiety
- ❑ Schizophrenia
- ❑ Other _____

Head, Eyes, Nose, & Throat
- ❑ Dizziness
- ❑ Headaches
- ❑ Blurred vision
- ❑ Hearing loss/deafness
- ❑ Loss of sense of smell
- ❑ Chronic nasal congestion
- ❑ Other _____

Cardiovascular
- ❑ Palpitations ❑ Murmurs
- ❑ Chest pain ❑ Stroke
- ❑ Heart attack
- ❑ Mitral valve prolapse
- ❑ Other _____

Breasts
- ❑ Discharge (clear? ___ bloody? ___ milky? ___)
- ❑ Lumps ❑ Pain
- ❑ Cancer ❑ Rash
- ❑ Abnormal mammogram
- ❑ Reduction ❑ Augmentation/implants
- ❑ Other _____

Genito-Urinary
- ❑ Bladder infections
- ❑ Kidney infections
- ❑ Vaginal infections
- ❑ Frequent urination
- ❑ Leaking urine
- ❑ Blood in the urine
- ❑ Other _____

Hematologic
- ❑ Blood clotting disorder/blood clot
- ❑ Sickle cell anemia
- ❑ Easy bruising
- ❑ Swollen glands/lymph nodes
- ❑ Blood transfusions (dates/reasons_____)
- ❑ Other _____

Respiratory
- ❑ Shortness of breath
- ❑ Asthma ❑ Bronchitis
- ❑ Pneumonia ❑ Asthma
- ❑ Bloody cough
- ❑ Other _____

Neurological Problems
- ❑ Weakness/loss of balance
- ❑ Seizures/Epilepsy
- ❑ Headaches
- ❑ Migraine headaches
- ❑ Numbness
- ❑ Memory loss
- ❑ Other _____

Skin/Extremities
- ❑ Unexplained rash
- ❑ Acne
- ❑ Skin cancer
- ❑ Excess hair growth
- ❑ Moles changing appearance
- ❑ Other _____

12. FAMILY HISTORY / GENETIC HISTORY

	Mother	Father	Brothers: #	Sisters: #	Children: #	Other
Cancer (type)						
Diabetes						
Hypertension						
High Cholesterol						
Heart Disease						
Stroke						
Uterine fibroids						
Endometriosis						
Menopause before age 40						

13. ETHNICITY **Data will be used for genetic testing recommendation purposes*

❑ Caucasian ❑ Hispanic ❑ Asian ❑ African American ❑ Other (_____)

Do you or anyone in either family have?

❑ Neural tube defects/spina bifida/anencephaly
❑ Cystic fibrosis
❑ Muscular dystrophy
❑ Tay-Sachs disease
❑ Sickle cell disease or trait
❑ Chromosomal disorder
❑ Genetic / inherited disorder

❑ Thalassemia
❑ Down syndrome
❑ Huntington chorea
❑ Mental retardation / fragileX
❑ Hemophilia
❑ Hormonal disorder
❑ Baby with birth defects
❑ Infertility

❑Hydrocephalus
❑Stillbirth
❑Epilepsy or seizures
❑Phenylketonuria
❑Kidney disease
❑Neurofibromatosis
❑Mental illness
❑Myotonic dystrophy

❑3 or more miscarriages
❑Diabetes

❑ Any birth defects? **❑ Any inherited disorders?**

Please explain a "Yes" answer to any of the above_____

_____

Genetic Screening:

It is recommended that **all couples** attempting conception be offered cystic fibrosis screening. Cystic Fibrosis is a pulmonary disease affecting children and the most common genetic disease. The effectiveness of the test varies dependent on your ethnic background. You may be offered additional screening based on your ethnicity. Are you: African-American ❑ Yes ❑ No

Ashkenazi Jewish ❑ Yes ❑ No Mediterranean/Asian/French Canadian ❑ Yes ❑ No

If you answered YES to any of these, please let your physician know at the visit, so that the additional genetic screening can be offered to you. If you have any specific genetic concerns and desire to see a geneticist, please let the physician know.

14. HISTORY OF FERTILITY THERAPY (Fill out if applicable)

Have you been treated for infertility previously? ❑ YES ❑ NO

If yes, who was your physician? ……..

What cause of infertility was diagnosed? ……

What drugs have you taken for infertility? Please check all that apply:

❑ Clomid (Serophene)
❑ Gonal F
❑ Follistim
❑ Repronex
❑ Pergonal
❑ Fertinex
❑ hCG Profasi
❑ Progesterone
❑ Lupron
❑ Microdose Lupron
❑ Antagon
❑ Parlodel
❑ Antibiotics
❑ Baby aspirin
❑ Heparin
❑ Steroids
❑ Oral Contraceptives
❑ Other ……..……

Which of the following tests have you or your partner had performed? Please check all that apply and results, if known:

❑ Hysterosalpingogram	When _____/_____/_____	Results ……..……..
❑ Sonohystogram	When _____/_____/_____	Results ……..……..
❑ Laparoscopy, Hysteroscopy	When _____/_____/_____	Results ……..……..
❑ Thyroid tests	When _____/_____/_____	Results ……..……..
❑ Chromosomes	When _____/_____/_____	Results ……..……..
❑ Genetic screening	When _____/_____/_____	Results ……..……..

❑ OTHER_____

Have you ever undergone Artificial Insemination (IUI) or In Vitro Fertilization (IVF)? ❑ YES ❑ NO
If yes, ❑ partner ❑ donor sperm #IUI's ____ #IVF cycles _____

At the UC Center for Reproductive Health, we understand that infertility can place a significant burden on the respective couple. This stress can have a profound impact on the reproductive system. Given these facts and our emphasis on treating the whole person, we would like to know your experience with / willingness to try alternative therapies. These include, but are not limited to:

- Acupuncture (if so, which acupuncturist)_____
  Dates: ❑ Current ❑ Previous _____
- Herbal treatment_____
  Dates: ❑ Current ❑ Previous _____
- Massage_____
  Dates: ❑ Current ❑ Previous _____
- Psychological/group therapy_____
  Dates: ❑ Current ❑ Previous _____
- Yoga / biofeedback / stress reduction techniques_____
  Dates: ❑ Current ❑ Previous _____

PATIENT'S SIGNATURE **DATE**

_____

I confirm that I have reviewed the above information.

PHYSICIAN'S SIGNATURE **DATE**

_____

Welcome and we look forward to working with you.
Please write down any specific concerns you want to review at your visit.

Thank you - The UC Center for Reproductive Health Team